



CABINET FOR HEALTH AND FAMILY SERVICES

OFFICE OF INSPECTOR GENERAL
DRUG CONTROL & PROFESSIONAL PRACTICES BRANCH
275 EAST MAIN STREET
FRANKFORT 40621-0001

For Office Use Only

Lic. _____
No. _____
Date _____
mailed _____

APPLICATION FOR RENEWAL LICENSE AS MANUFACTURER OR WHOLESALE OF CONTROLLED SUBSTANCES

All licenses expire June 30 and are not transferable. Please type application and submit to the above address with check or money order made payable to the Kentucky State Treasurer in the amount of \$175. 00.

1. The undersigned hereby makes renewal application for a ☐ **Manufacturer's**, or ☐ **Wholesaler's** (Check Only One) Controlled Substance License under the provisions of KRS 218A

b. Schedule(s) ☐ II ☐ IIN ☐ III ☐ IIN ☐ IV ☐ V (Check all that apply)

c. ☐ 1,4 Butanediol, Gamma-Butyrolactone, GBL, Dihydro-2(3H)-furanone, 1,2-Butanolide, 1,4-Butanolide; 4-Hydroxybutanoic acid lactone, gamma-hydroxybutyric acid lactone (Code of Federal Regulations 21 Part 1310.02 (a)) – Industrial Use Only – Not for human consumption

2. Name of Licensee: _____

Address: _____

Telephone: _____ Email: _____

3. All trade or business names: _____

4. Contact person(s) for the handling, storage or recordkeeping of controlled substances (attach additional pages if necessary):

Name

Address

Telephone

Name

Address

Telephone

5. Type of ownership:

☐ Individual/Sole Proprietorship

Name _____

Address _____



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☐ Partnership: (Attach additional pages if necessary)

Name of Partnership

Name of Partner

Name of Partner

Address of Partner

Address of Partner

☐ Limited Liability Company: (Attach additional pages if necessary)

Name of LLC

Name of Manager or Member

Name of Manager or Member

Address of Manager or Member

Address of Manager or Member

☐ Corporation

Name of Corporation

State of Incorporation

Name and title of each corporate officer and director: (Attach additional pages if necessary)

Name

Name

Title

Title

Name

Name

Title

Title

Name

Name

Title

Title



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6. Describe the business, the physical facilities, and the type security provided. (Attach additional pages if necessary)

7. DEA number of licensee: _____ Expiration date _____

8. Has applicant or any partner, officer, director or agent ever been convicted of a misdemeanor involving any controlled substance?

☐ Yes (attach explanation) ☐ No

9. Has any applicant or any partner, officer, director, or agent been convicted of any felony?

☐ Yes (attach explanation) ☐ No

Changes in the above information must be submitted on form DCB 11 within 30 days or at the time of renewal, whichever occurs first.

I understand that the Cabinet for Health Services shall be notified in the event of any theft or other loss of controlled substances. Any problem, such as pilferage, which develops in a facility, must also be reported. Assistance may be available if desired.

I hereby certify that all answers given in this application are true, complete and correct and I understand that any license issued to me by the Cabinet for Health Services may be suspended or revoked for cause.

Printed Name & Title of Applicant

Signature

Date

FOR OFFICE USE ONLY

Date application received _____ Date Fee Received _____